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AIDS EDUCATION  
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# HIV Clinician

formerly FACULTY NOTES

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## Cidofovir: progress in the treatment of Progressive Multifocal Encephalopathy (PML)?

Ronald D. Wilcox MD

Progressive multifocal leukoencephalopathy is a demyelinating disease of the white matter of the brain caused by the polyoma JC virus. It is prevalent worldwide with a seroprevalence rate of 80% in adults. It is a cause of severe morbidity and mortality as an opportunistic infection in patients with AIDS. Frequency in these patients is approximately 5%. The prognosis in general has been very poor with the median survival time after diagnosis of four months. Highly active antiretroviral therapy (HAART) has been shown to slow down or reverse the progression of the disease, but many cases will progress despite good responses in viral load counts and CD4 counts. Despite the wide use of HAART therapy, the prevalence of PML in patients with AIDS has not decreased. Cidofovir, an acyclic nucleoside phosphonate derivative used in the

treatment of the herpes viruses, has been shown anecdotally to be an effective adjunctive therapy in some patients.

Raymund R. Razonable, MD, et al recently reported another case and reviewed 19 cases in the literature in the November 2001 issue of the *Mayo Clinical Proceedings* journal. All of the patients presented with similar radiologic and clinical findings. 75% had confirmation by either isolation of JC virus DNA in the CSF or characteristic histology of the brain. Of the 19 reviewed patients, only eleven had the age reported; all were men in the age range of 34 to 55 years with a mean age of 43. The interval between the initiation of HAART therapy and the onset of symptoms of the PML was a range of two weeks to one year. The mean CD4 count at the time of diagnosis was 220/ml and the HIV RNA viral load had a range of below 50 to a

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### Psychosocial

## Evidence-Based Practice: implications for social work in AIDS care

Valerie Gordon-Garofalo, MSW, PhD

New mandates require social workers to engage in "evidence-based practice." What does this new terminology mean, and how does it change social work

practice and the delivery of HIV/AIDS-related social services?

Evidence-Based Practice (EBP) is a process by which social workers and other practitioners pose treatment-planning questions, search for the

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## Medicine

# Many cases of PML progress despite good responses to HAART

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little over 8000 copies/ml. For those with a baseline CD4 count reported, there was an average increase of 460% from the baseline value *at the time of or prior to* the development of symptoms of PML. The effect seen by HAART therapy is usually either slowing or cessation of progression of disease, but not reversal of the process.

PML occurring with the patient receiving HAART therapy is felt to be due either to immune reconstitution, partial immune recovery, or a more virulent JC viral strain. HAART may induce the conversion of latent disease to symptomatic by immune reconstitution with an inflammatory response to the incubating subclinical infection. P. Miralles et al reported this year a case of worsening findings on MRI after initiation of HAART, suggesting that the disease in patients on HAART therapy may differ from those not on HAART. Partial immune recovery without recovery of immunity aimed at JC virus and a more virulent strain are felt less likely to be the explanation in these patients.

Cidofovir has broad activity against the Herpesviridae family and has been approved by the FDA for use in the treatment of cytomegaloviral retinitis. The mechanism of action against PML is unclear; there is direct anti-polyomaviral activity by the medication but, given that PML after HAART may be immune-

mediated, cidofovir may also have some anti-inflammatory action. There have been conflicting reports of its efficacy in the use of treatment for PML in the literature. Presented at the 8<sup>th</sup> conference on Retroviruses and Opportunistic Infections in February 2001 was an open-label nonrandomized trial by the ACTG 363 of 24 patients who did not show any increase in survival whereas a study reported by Berengue et al of 118 patients suggested a likely association between patient survival and the use of cidofovir.

In a report by De Luca et al in the *Journal of Neurovirology* in August 2001, their group consisted of 27 patients treated with HAART alone versus 16 patients treated with HAART plus cidofovir 5 mg/kg IV per week for the first two weeks then every other week, along with probenecid. One patient had to be removed from the cidofovir treatment arm secondary to the development of severe proteinuria. Probability of survival at one year was 0.29 in the group treated with HAART alone and 0.61 in those treated with both HAART and cidofovir (log rank test  $p = 0.02$ ). Measurement of JCV DNA in the CSF two months after initiation of therapy was undetectable in 42% of patients tested who were on HAART therapy alone and was undetectable in 87% of those on combined therapy ( $p=0.04$ ). Baseline characteristics, including those previously proven to be relevant to disease

progression, were similar in both groups.

HAART remains the mainstay of therapy to assist with the control of PML. Although there is not conclusive evidence of the effectiveness of cidofovir as demonstrated by randomized case-controlled studies, there are a number of anecdotal reports that suggest that consideration can be made for its use as an alternative therapy in those patients who have progression or no improvement in the disease while on highly active antiretroviral therapy (HAART).❖

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## Psychosocial

# Social workers tend not to engage in evidence-based practice

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current best practices, and deliver interventions based on sound guidelines (Gibbs, 2002). It is simply making practice decisions on the best available research evidence or, in their absence, utilizing well-formulated standards of care.

While new graduates of MSW and other health science programs will be proficient in gathering evidence for practice, those who have been working in agencies for a few years may not understand this new jargon or the requisite implementation process. In fact, a recent study showed that social workers in the work force tend not to engage in evidence-based practice, know what it means, or understand what it entails (Mullen & Bacon, 2000). However, social workers are very interested in applying these methods once explained, and implementing evidence-based practice is easy.

### Steps in EBP

The process of evidence-based practice follows several steps, according to Gibbs (2002), who adapted for social work the framework that medical doctors use (Sackett, Richardson & Haynes, 1997). The following is a condensation.

*Asking answerable questions.* EBP is best applied when social workers can access technology to consult the current best evidence quickly. Converting information needs into specific

questions allows us to guide a computer search or seek other consultation as the situation is unfolding and soon enough to guide our decisions about treatment options (aka “just in time”). A good question, like a good treatment plan, is always developed with the client’s input and has four components. It identifies (1) the client type and problem, (2) what you might do to address the problem, (3) alternative action steps, and (4) what you want to accomplish. The clinician generally asks questions that address one or more of five dimensions: treatment effectiveness, prevention, assessment, description, or risk. Especially important are how these aspects of practice apply differently to diverse client types (e.g., for men vs. women, low income vs. affluent, those with higher levels of education vs. those who are minimally educated), with different units of attention (e.g., for individuals vs. families, groups, or organizations), and in different settings (e.g., in-home vs. agency or clinic). An example of a question that addresses effectiveness might be (1) If a newly diagnosed African-American female client shows signs of depression, (2) is referred to a psychoeducational group, (3) or given individual cognitive-behavioral counseling, (4) which will result in a return to normal-level functioning most effectively? Questions resemble the traditional treatment plan approach, taught in almost all schools of social work and used in most HIV/AIDS case manage-

ment and mental health agencies.

*Tracking down best practices.* The most efficient way to locate evidence of effective treatment options is to run a computer search. This requires access to electronic databases or Internet search engines and skill in searching them. It is beyond the scope of this article, but instruction in conducting computer-based evidence searches is available through many channels. Schools of social work are offering continuing education workshops, as are HIV/AIDS social work conferences. As well, soon to be released is an excellent guide from Brooks/Cole Publishing (Gibbs, 2002). Other information is quickly becoming available through journal articles, web-based information, and clinical guide books (Corcoran, 2000).

Sources for gathering information include: libraries (both public and university), Delta ETC and other ETC web sites, websites related to social work practice and/or HIV/AIDS care, professional associations and their on-line and printed journals, and internet search engines. The Delta ETC website provides access to medical resources and their related behavioral components through searchable databases, such as PubMed, NLM Gateway, and MedScape. University and medical school library databases are available on a limited basis to non-affiliated professionals. Field instructors of social work

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interns share full library privileges, including Internet account access, which allows off-site database search. Of particular interest to social work practitioners are the Silver-Platter databases: Social Work Abstracts, PsychInfo (psychology-based), SocioFile (sociology-based), and ERIC (education-based). Purchasing portable databases for agency use is an option. A less expensive option may be database sharing through a consortium or resource network arrangement. We should also advocate for social work relevant database inclusion in HIV/AIDS information clearinghouses.

*Critically appraising the evidence.* According to Gibbs (2002), this step implies applying a “hierarchy of evidence,” whereby one rates the evidence provided. Studies that use comparison or control groups, probability sampling, clearly defined treatment approaches, adequate numbers of participants, valid and reliable measures, and appropriate statistical analyses are, of course, rated higher than those which do not employ such rigor. A parallel appraisal of feminist, qualitative studies requires examining the validity of interpretations and participant involvement in the research process.

When there is not sufficient evidence in a search of the professional literature to justify one treatment or assessment method over another, one should first turn to sanctioned standards of care or practice guidelines, then rely on super-

visory or peer consultation and one’s own practice wisdom.

*Applying the Results.* In this step, the clinician must decide the extent to which evidence gathered applies to the decision at hand. Are the clients similar enough to those described/ studied? What about access to the preferred interventive strategies? Practitioner strength in delivering the identified best practice?

*Evaluating Performance.* Keeping adequate records, documenting service delivery and client satisfaction, and evaluating outcomes is a necessary part of EBP. Social work successes tend to be anecdotal (Vallianatos, 2000). Needed, instead, is clear documentation of service eligibility; clearly articulated rationales for service structure and components; the use of structured assessment tools for identifying individual risk factors and assigning clients to service level; evidence-based interventions, derived from clinical efficacy trials; and documentation and evaluation of program outcomes, to justify the results of programs (Voourlekis, Ell, Nissly, Padgett, & Pineda, 2001). Most, if not all, of these components are present in our state and regional HIV/AIDS service systems. Evidence that social work interventions are effective must be documented in-house, shared with funders and client stakeholders, discussed in consortia, presented in professional forums, and published for those outside the field. For example, task-centered brief treatment works, as do case management and

discharge planning in HIV inpatient settings (Vallianatos, 2000), but if evidence is not made public, it cannot be viewed as best practice.

### **Ways to implement EBP in HIV/AIDS care**

*Becoming motivated.* Gibbs (2002) states that for social workers, the motivation toward EBP will probably come from our dedication to do no harm, our determination to make better practice decisions, and our commitment to collaborate with

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**Implementing  
evidence-based practice  
can be an easy task,  
once understood.**

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our clients. Mullen and Bacon (2000) found that social workers are open to using clinical practice guidelines and empirically informed practice as long as it is perceived as helping clients. EBP can provide a source of clinical knowledge that improves practice. It gives us the opportunity to combine the best of science available with clinical experience to better serve a wide variety of clients (Sexton, 1999).

*Standards of care.* Standards of care are important reference tools for the profession and serve as evidence of best practice (Vallianatos, 2000). These guides tend to be user-friendly and are more accessible to practitioners than research findings published in journals.



Clinical practice guidelines are often formulated by professional organizations and government agencies, prescribing how clinicians are to assess and treat clients. Sometimes the guides are based on research findings, but oftentimes they are based on professional consensus (Mullen & Bacon, 2000). An excellent example is the Ryan White Title 1 Standards of Care for Case Management. The Service Delivery Committee of the New Orleans Regional AIDS Planning Council developed the practice guide through consensus. The committee, comprised of agency and practitioner representatives, as well as members of the affected community, used a combination of theory, published research evidence, practice experience, expert consultation, and service utilization data derived locally to create the document.

*Consultation, training and continuing education.* Social workers tend to rely more heavily on consultation than upon reviewing professional literature. Social workers seek direction and guidance from supervisors and other consultants and respect authority, practice wisdom, and experience (Gambill, 1999; Gambill, 2001; Mullen & Bacon, 2000). Important resources for dissemination of EBP knowledge within social work agencies, then, are colleagues who engage in practice research and/or are familiar with current literature (Mullen & Bacon, 2000). Inservices, training programs, certificate and continuing education coursework, and conferences are excellent ways for social workers and other

health care associates to become informed of empirically supported interventions. Some “just in time” learning modules are available on-line, through universities, licensing bodies, professional organizations, and for-profit agencies, such as pharmaceutical companies.

*Collaboration with Schools of Social Work.* Aside from consultation and education/training programs, schools of social work provide access to library reference and journal materials and can assist agencies in program and service evaluation. Faculty have research skills that can be of value to agencies and autonomous clinicians, and often have masters and doctoral students available to collect and analyze data. Such services can be provided as formal program evaluation or informal assistance. Noted in the literature is the value of university-based research centers in developing policies and evidence-based practices (Iwaniec & McCrystal, 1999).❖

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## Clinical Consultation for Health Care Providers

Delta Region health care  
providers can consult  
with HIV experts at  
university medical centers:

- Louisiana 504-903-0788
- Mississippi 601-984-6105
- Arkansas 870-535-3062

#### National Consultation Lines:

- National Warmline  
800-933-3413
- National PEpline  
888-448-4911

For the latest in  
HIV treatment  
guidelines:

[www.hivatis.org](http://www.hivatis.org)



## Dentistry

# *With HAART success, managing dental caries is again important*

Nick Mosca, DDS

For at least the past twenty years, much attention has been given to the oral opportunistic infections that affect persons with AIDS. With the number of cases of AIDS in decline, the identification and management of conventional oral disease, i.e. dental caries, returns as an important health consideration for persons living with HIV (PLWH). The recent Surgeon General's Report, *Oral Health in America*, defines an oral disease as any condition of the mouth that interferes with daily activities such as eating, swallowing, and speaking. Dental caries, or tooth decay, is considered the most common oral disease, affecting more than 90% of all adults in the United States. Dental caries is an infectious disease caused by cariogenic microorganisms metabolizing fermentable carbohydrates provided in dietary intake. Studies using germ free animals has shown that caries does not occur without bacterial infection.

*Streptococcus mutans* is the most virulent cariogenic microorganism, with lactobacilli, enterococci and actinomycetes contributing to a caries-tolerant environment. *Streptococcus mutans* appears to spread vertically in the populations, primarily by close contact between mother and child, even through breast-feeding. Persons with higher fermentable carbohydrate amounts in their diet, for example by

consumption of beverages that contain sucrose, will have higher titers of cariogenic bacteria in the mouth. Human genetic studies in which participants must avoid sucrose consumption (i.e. hereditary fructose intolerance and intestinal sucrase deficiency) support the hypothesis that sucrose does have a great impact on both colonization of the teeth by cariogenic bacteria, and the development of dental caries.

The dental caries process begins with the loss of calcium ions from the surface apatite crystals that form the bulk of the three calcified tissues of a tooth: enamel, dentin, and cementum. Alternately under normal conditions, enamel demineralization is dynamically compensated for by remineralization, a dynamic process when favorable conditions are present in the mouth. Do PLWH have increased dental caries risk secondary to compromised host immunity? Are other risk factors prevalent in PLWH? What precautions should PLWH take to reduce the risk for dental caries?

Besides cariogenic dietary considerations, PLWH may have increased risk for dental caries by association with modified salivary factors. Saliva has buffering capacity to reduce acidity, and contains immunoglobulins, specifically salivary IgA, as well as innate non-immunoglobulin factors. Chronically low salivary rate is one of the strongest indicators for increased risk for caries prevalence, probably by the loss of the protective features listed

above. Alterations in oral saliva production may be pathologic from HIV infection and salivary gland dysfunction, or may result from the xerostomic side effects of certain medications. Medications that inhibit cholinergic signaling pathways in salivary tissues decrease the production of saliva, and include antidepressant and anti-anxiety medications that PLWH may be taking.

Conservative management of caries-active individuals includes behavioral modification, fluoride varnishes, fluoride rinses, chlorhexidine rinses, and combined chlorhexidine rinses and occlusal sealants. All health care providers should be attentive to those behaviors that contribute to this oral infectious disease. PLWH must be motivated by all health providers to engage in behaviors that will reduce morbidity. The most effective self-regulatory behavior is tooth brushing with a fluoridated dentifrice. Lessons in effective tooth-brushing technique should be given, preferably with direct supervision of a person's technique with feedback for improvement. Xylitol chewing gum has been shown to be effective in reducing cariogenic risk, but the proposed mechanism of Xylitol's effectiveness is unclear. PLWH may be encouraged to use this product. Tobacco cessation programs should be recommended for those who smoke or use smokeless tobacco products. Mothers of children



with HIV should be advised of feeding habits that will prevent caries. Dental sealants, polymers that adhere to the grooves and fissures of teeth, are very effective in preventing pit and fissure caries in children.

Nutritional counseling should include recommendations to prevent dental caries. Twenty-four hour diet recall interview, three-day diet diary, and food frequency questionnaires should be considered when conducting HIV early intervention assessments. Sugar consumption in high frequency should be avoided, unless caloric intake is severely compromised without such. In such cases, behavioral modification to reduce caries should be emphasized. Doctor-prescribed fluoride gels and varnishes provide topical protection against cariogenic microorganisms, and dental referrals can determine the best product for the PLWH to receive. The appropriate fluoride regimen would include semi-annual topical application of a fluoride varnish containing 22,600 ppm of fluoride to a noncavitated carious lesion, or more frequently as indicated. Daily fluoride application at home should include a fluoride dose of 5,000 ppm, as a NaF or APF preparation. Some researchers question the use of topical antimicrobial agents such as 0.12% chlorhexidine rinse as a "shotgun suppression of the entire microbiota," yet caries reduction has been reported with regular use of such products. Further research to target specific cariogenic microbes with such products is needed.

Attention to salivary function should be given to PLWH, with treatment of salivary dysfunction

as indicated. A review of medications with anticholinergic effects should be conducted as a part of primary care, to identify those with increased risk for caries. There is no conventional therapy to enhance salivary secretions for those with salivary gland disease. However, there are two drugs approved as secretagogues for persons with radiation-induced salivary gland hypofunction and Sjögren's syndrome, pilocarpine (Salagen®) and cevimeline. These drugs activate muscarinic receptors in the salivary gland to secrete saliva, but they do not address the underlying inflammatory processes or tissue pathology that induces the hyposalivation.

In addition to screening for oral opportunistic infection, persons living with HIV should be informed of the value of preventing dental caries to improve their health, reduce complications from odontogenic infections, and improve health outcomes. ♦

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### **Check out the NRC's ASK THE EXPERTS Forum**

A resource and discussion group for clinicians regarding the PHS AIDS/HIV Treatment Guidelines. Especially helpful with gaining insight into new versions of the Guidelines.

A service of the AETC  
National Resource Center:  
<http://www.aids-ed.org/>

## **New guidelines for prevention of OIs**

Now available: 2001  
USPHS/IDSA Guidelines for  
the Prevention of  
Opportunistic Infections in  
Persons Infected with  
Human Immunodeficiency  
Virus.

The new guidelines, which  
were released on November  
28, provide information for  
preventing OIs in persons  
infected with HIV.

A list of the major changes  
can be found on page 7 of  
the documents. Some of  
these changes:

- The importance of screening all HIV-infected individuals for hepatitis C virus (HCV) is emphasized;
- Additional information about transmission of human herpesvirus 8 infection (HHV-8) is provided;
- New information on drug interactions is provided, especially with regard to rifamycins and antiretroviral drugs;
- Revised recommendations for immunization of HIV exposed/infected adults and children are provided.

The guidelines can be  
viewed or downloaded at  
[http://www.hivatis.org/  
trtgdlns.html#Opportunistic](http://www.hivatis.org/trtgdlns.html#Opportunistic)



## Nutrition

### L-Carnitine for the treatment of hypertriglyceridemia in HIV

Ginger Bouvier, MEd, LDN, RD

Research indicates that some antiretroviral medications, particularly protease inhibitors, may cause significant elevations in serum triglyceride levels.<sup>1</sup>

Hypertriglyceridemia can increase the risk of coronary artery disease, and may also lead to pancreatitis.

Triglyceride levels are classified as follows:<sup>2</sup>

Normal.....	<200 mg/dL
Borderline high.....	200-400 mg/dL
High.....	400-1000 mg/dL
Very high.....	>1000 mg/dL

Diet modification and exercise are usually the first steps in the treatment of hypertriglyceridemia. Dietary intervention includes weight control, decreasing total fat intake (25-30% of total calories), consuming mainly mono- and polyunsaturated fats, limiting carbohydrate intake (50% of total calories), reducing simple sugars, eliminating alcohol, and increasing fiber. Patients with severe hypertriglyceridemia may need to reduce total fat intake to 10 to 20% of total calories to prevent pancreatitis. Aerobic exercise three to four times per week for thirty minutes may also help reduce serum lipids. To achieve marked reductions in HAART-associated hypertriglyceridemia, the use of lipid-lowering drugs (such as Atorvastatin and Gemfibrozil) is often required in addition to diet and exercise.

Another possible therapeutic approach to hypertriglyceridemia is the nutrient L-carnitine. L-carnitine has been shown to produce significant decreases in serum triglyceride levels in HIV infection. Research on L-carnitine deficiency in AIDS revealed a strong reduction ( $p<0.05$ ) of serum triglycerides in patients treated with high-dose (6g daily) oral L-carnitine, in the absence of antiretroviral therapy.<sup>3</sup> No undesirable side effects were observed.

In a recent pilot study, significant reductions in triglyceride levels were observed in a group of HIV-infected adults who received oral L-carnitine (3g daily), compared to a control

group.<sup>4</sup> The authors noted near-normal triglyceride levels in 54% of subjects after two months of L-carnitine. No significant effects on other metabolic abnormalities were observed.

Carnitine is an amino acid derivative which plays a critical role in cellular energy metabolism. It is required for transport of long-chain fatty acids across the mitochondrial cell membrane, where they undergo beta-oxidation. In humans, 75% of the body's carnitine stores are derived from the red meat and dairy products. The remaining 25% are synthesized in the liver and kidneys from the essential amino acids lysine and methionine. Successful synthesis of carnitine is dependent on the presence of vitamin C, vitamin B<sub>6</sub>, iron, and niacin. There is no recommended daily allowance for carnitine.<sup>5</sup>

More research is needed on the use of L-carnitine in HAART-associated hypertriglyceridemia. However, the available data does suggest a possible role for L-carnitine. L-carnitine is available over-the-counter as a dietary supplement, usually in 250mg or 500mg tablets. Carnitor (Levocarnitine) has the brand name of L-carnitine, is available by prescription and may be covered by Medicaid in some states. ♦

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## Plan ahead to attend HIV conferences...

▲ February 24-28, 2002  
**9th Conference on Retroviruses and Opportunistic Infections**  
Seattle, Washington  
<http://www.retroconference.org/2002/about.htm>

▲ March 17-21, 2002  
**15th International Conference on Antiviral Research**  
Prague, Czech Republic  
<http://www.isar-icar.com/icarmain.html>

▲ April 24-27, 2002  
**12th European Congress of Clinical Microbiology and Infectious Diseases**  
Milan, Italy  
<http://www.akm.ch/eccmid2002/menue.htm>

▲ April 25-28, 2002  
**12th Annual Clinical Care Options for HIV Symposium**  
Key Biscayne, Florida  
<http://www.imedoptions.com/>

▲ July, 2002  
**XIV International AIDS Conference**  
Barcelona, Spain  
[http://www.aids2002.com/IE\\_home.asp](http://www.aids2002.com/IE_home.asp)

▲ September 27-30, 2002  
**42nd Interscience Conference on Antimicrobial Agents and Chemotherapy**  
San Diego, CA  
<http://www.icaac.org/ICAAC.asp>

▲ December 17-21, 2002  
**HIV DART 2002: Frontiers in Drug Development for Antiretroviral Therapies**  
Puerto Rico  
<http://www.informedhorizons.com/HIV-dart2000/index.php>

Please make a note of  
Delta ETC's  
new phone number  
504-903-0788



## Nursing

# Ryan White CARE Act to focus on HIV-infected incarcerated

*Patricia Gootee, MSN, C-FNP*

In an unprecedented move, HRSA (Health Resources and Services Administration), which is the disseminating agency for Ryan White CARE Act funds, unveiled its plans in April of this year to include incarcerated HIV-infected individuals for expenditures under the Act. Previous to this announcement, Ryan White Care Act funding was considered “funds of last resort,” excluding the incarcerated, because they were thought to be the sole burden of local, state, and federal correctional systems.

HAB Policy notice 01-01, dated July 23, 2001, describes how Ryan White Care Act funds “may be used for transitional social support and primary care services for incarcerated persons as they prepare to exit the correctional system,” including non-institutional settings such as pre-release residential half-way houses.

In general, the intent of the Act is to ensure that eligible HIV-infected persons have access to HIV treatment and care. HRSA recognizes that the prevalence of HIV in correctional settings is high and that most infected individuals will go back to the communities from which they came, thus becoming the responsibility of the Care act. Early detection, entry into care, access to and continuity of care are important reasons to use CARE Act funds for incarcerated persons.

Grantees wishing to utilize CARE Act funds for this purpose will need to establish linkages with correctional administrators in order to determine the gaps in services that correctional systems are legally required to provide. The purpose of this policy is not to supplant resources that are available to the incarcerated person, and the responsibility of the correctional system. Transitional case management is generally not a legal requirement for correctional institutions to provide. Transitional primary care services can also be provided on a short-term basis in an outpatient setting by grantees.

Transitional Social Services links the incarcerated person prior to release to services in community-based systems of care. Transitional Primary Care Services are services delivered in an outpatient setting, which include comprehensive continuum of care and prescription drugs. The exact timeframe for providing these services is flexible, “and to be determined in collaboration with the Care Act project staff, involved in care during and after release, and the correctional institution’s medical staff who are providing the care while the inmate is in custody and based on inmate needs.” The directives go on to include mechanisms of accountability for the use of CARE Act funds in this matter.

The paradigm shift in the CARE Act usage is directly

related to the shift in the populations now facing HIV in 2001 and beyond. By slow but steady emergence, the drug culture has changed the “Face of HIV/AIDS” to look like anyone interfacing with the culture of buying, selling and using substances of abuse. As service providers of HIV care, we can no longer treat the infection without trying to treat the underlying cause, and eventually, its underlying cause.

HRSA recognizes that we have to begin this process somewhere, even if it is closing the gate “after the horse is out of the barn.” The benefit of starting over with our incarcerated patients and helping them remove the barriers to care and rehabilitation is far reaching. As bad deeds affect not only the perpetrators, but also their families and communities, so do thoughtful planning and participation in positive behaviors resound within their families and communities. Perhaps this new way of thinking about the Ryan White Care Act will prove to be the beginning of the end of HIV, a new way of looking at secondary prevention. ♦

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## Mental Health

# Don't ask don't tell don't work when it comes to suicide and HIV

Jill Hayes Hammer, PhD, and  
Byron A. Hammer, MD

"Max" is a forty-nine year old man who has had AIDS for several years, chronic pain, an enlarged prostate, dental problems and a host of other medical complications. He has a history of alcoholism and has abused narcotics in the past, but has been abstinent for fifteen years. Over that last two to three years, he developed intermittent depression with anxiety and panic attacks, and has significant insomnia. He has at least weekly doctor appointments, is living on social security disability, has lost several friends either from AIDS or as a result of prejudice about AIDS, and is watching his partner of many years waste away from the illness. Unfortunately, while Max's situation may seem extreme, the medical and life difficulties he faces are all too common in individuals with HIV. And like Max, patients with multiple medical and psychosocial problems are more at risk for contemplating and completing suicide.

The relationship between contracting HIV and committing suicide is complex, however. Some researchers have found that individuals with an AIDS diagnosis are at much greater risk for suicide than those who are HIV negative. For example, Mancoske, Wadsworth, Dugas, and Hasney (1995) reviewed the Louisiana vital statistics records and found that between 1987 and 1991, individuals with AIDS were 134.6 times more likely to complete suicide than the general

population, with individuals in the rural areas of Louisiana being at higher risk than individuals in the metropolitan New Orleans area. Several studies by Marzuk and colleagues (1988, 1997) found similar risk for AIDS and suicide, as well as a risk for suicide and HIV positive status. In their earlier study, they found that individuals often committed suicide within nine months of learning their HIV status, and in the latter study, they found that 70% of those who committed suicide had no signs of AIDS-related complications at autopsy. However, in one Marzuk et al (1988) study and in the Mancoske and colleagues study, these individuals also had complicating psychiatric and substance abuse problems, making a clear correlation between HIV status alone and suicide more difficult. Unfortunately, as the illness progresses and individuals develop AIDS, psychiatric complications increase, along with a worsening risk of suicide.

Primary care clinicians are the front-line treaters of patients with HIV and are more likely first to see risk factors for suicide in these patients. Recognizing and responding to these risk factors will help clinicians in working with HIV patients and with knowing when to refer them to see a mental health professional. Underscoring this fact is that, in the Marzuk (1988) study, 25% of the patients committed suicide while on medical units of general hospitals.

Of those who were HIV positive or who were diagnosed with AIDS and who committed suicide, most (approximately 80%) were men,

ages 25 to 55 (Marzuk, et al, 1997). Additionally, a significant proportion (approximately 66% in some studies) was African-American or Hispanic. While these demographics are important, understanding the overall risk factors for suicide in this population is crucial. The most significant risk factors are psychiatric illness, especially depression and anxiety, as well as substance abuse and alcoholism.

Other risk factors include:

- Organic mental disorder
- Past depression and previous suicide attempts
- Social isolation
- Limited support system
- Hopelessness; wishing for death
- Untreated pain or fatigue
- Bereavement
- Agitation and impulsivity versus a slowed-down mental state
- Inadequate coping skills
- Giving away prized possessions

Factors assumed to be specific to homosexual men include:

- Family history of rejection due to homosexuality
  - History of employment or legal problems as a result of being gay
  - An attitude that the "world is a dangerous place to be gay"
  - Engaging in homosexual behavior but avoiding identification with the gay community
  - Unsettled sexual identity
- (Houston-Vega & Ward, 1998)

Suicidal attempts can take several different forms. The most easily recognized are active attempts such as overdosing on medications, falling from a height, or hanging. These are the three most common means of completed suicide in both HIV positive individuals and HIV negative control groups. Passive



suicidal gestures may include risk-taking behaviors such as noncompliance with medications, increased substance abuse, driving while intoxicated, and possible indiscriminate unprotected sex.

Primary care clinicians should never be afraid to ask nonjudgmental questions about the cardinal symptoms of depression and suicidality. Specifically ask directly: "Have you been thinking that life is no longer worth living," "Have you thought about trying to kill yourself," and if the patient has, how has he/she thought about doing it. Asking why the patient is thinking of suicide now and what might reduce suicidal potential (e.g., reduce pain or depressive symptoms) is also important.

Suicidal ideation or thinking that he/she wishes to be dead is not in and of itself a potent risk factor. Thoughts of suicide are not uncommon in individuals with HIV. The problem worsens when a patient develops a specific suicidal plan and clear intent to die. Some clinicians fear that asking these questions may plant suggestions in patients' minds; however, research has repeatedly shown that raising the topic does not increase the risk of someone attempting suicide. In fact, research has shown that despair increases when physicians try to change the subject, cheer up the patient, or emphasize only the positive aspects of the patient's life (i.e., you have such a wonderful, supportive family) when he or she initiates a discussion about depression and suicide (Valente & Saunders, 1998).

If the patient endorses suicidal ideation without intent, the primary care clinician should

determine if the patient would be willing to see a mental health professional. How the doctor presents the discussion about mental health services has a profound impact on how open patients will be to receiving services. One way to open the discussion is to say, *"I'm worried about you. We have a good relationship and I respect your honesty in being open with me. I want to respect you back by being the best doctor I can for you. Sometimes that means asking for help from colleagues. I'd really like for you to go talk to someone who has more experience in helping with these kinds of problems. Just like you would want me to send you to a specialist if you have kidney or heart problems."*

If the patient is unwilling to see a mental health professional, and the primary care physician feels comfortable with the patient being at low risk for self harm, then the physician should make a note to discuss the topic again and say to the patient, *"Let's at least think about it and talk about it next time."* Not letting the topic drop just because they say no the first time will underscore the physician's care and concern for the patient, and will usually lead to less resistance in seeking psychiatric care.

If the patient has a plan and is intent to die, more active measures are necessary. Address the issue directly, saying something along the lines of *"I'm very worried about you. When it gets to this point, people often have a hard time thinking clearly or seeing all their best options. Because of that, I want you to see a mental health person now."* If no mental health professional is available, a physician emergency

commitment (PEC) should be initiated or 911 should be called.

Supportive, caring clinicians often instill hope in their patients by letting the patient know that he/she will not be alone during the disease process. In Max's case, his primary care physician took the initiative early and talked with him about his anxiety and depression. He directed him to group therapy first, and when needed, he referred him for psychiatric consultation. Max was successfully treated for his depression and panic attacks, and even though he still faces an array of discouraging medical and life problems, he voices an unrelenting enthusiasm and hopefulness that is inspiring to all who work with him. Much of this optimism stems from the fact that his primary care physician showed that he cared about every aspect of Max's life, and helped him get the help he needed.❖

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